Art for the Heart Counseling

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Child-Adolescent Intake Form

Please provide the following information about your child:

Child's Name:	Nickname:
Birth Date:	Today's Date:
Address:	Phone:
Parent(s) names or primary guardian:	Parent(s) contact numbers: Home: Cell: Work:
In case of emergency, who may I contact on your behalf?	Name:
Phone number:	Relationship:
Ethnicity/Race:	Languages:
How did you hear about Art for the Heart Counseling?	Does your child enjoy art and creative expression?

School History

What school does your child attend:	Teacher's Name (Elementary)"
Current Grade:	Has your child ever repeated a grade? YES/ NO If so which one(s)________
Favorite Subject:	Least Favorite Subject:
Does your child receive Special Education service? YES/NO	Does your child receive tutoring? YES/ NO

Is your child in a gifted/talented/honors program? YES/ NO	Does your child like school? YES/ NO
Has your child experienced any of the following at school? (please circle all that apply) Fighting, suspension, lack of friends, gang influence, learning disabilities, incomplete homework, drug/alcohol, poor attendance, behavior problems, detention, poor grades	
Has your child been the victim of bullying or bullied other children? YES/ NO. If yes, please describe:	
Please, use the space to provide any other additional information regarding your child's education or developmental history that you find significant:	

Medical History:

Pediatrician's Name:	Phone:
Is child under the care of another medical specialist? YES/NO If yes, type of specialist ________________	Phone:

Please list any chronic illness, disabilities, medical conditions that your child has been diagnosed with:

Illness/Disability:	Dates:

List all medications that your child is currently taking:

Medication:	Dosage:	Treating:

Has your child ever experienced any serious emotional losses (such as a death of or physical separation from a parent or other caretaker)? YES/ NO. If yes, please explain:
Has your child ever experienced any traumatic incidents (assault or violence, physical/sexual abuse, exposure to domestic violence)?
Are there any behaviors that your child currently does too often, too much, or at the wrong times that gets him/her in trouble? YES/NO. If yes, please describe:
Are there any behaviors that your child fails to do as often as you would like or when you would like?
Please list positive strengths of your child: (What do you like about your child? What do others like about your child?)
How would you describe your child's self-esteem?

Briefly describe your reason(s) for seeking help at this time?
What goals do you wish to accomplish during the therapy process as a parent?
What goals does your child wish to accomplish during the therapy process? (can be different than parent's response)
Wherever possible, working with the parent/guardian is important to the treatment. Are you willing to be available as needed? YES NO MAYBE

Family History:

Mother's Name Occupation:		Father's Name: Occupation:	
Step-Mother?		Step Father?	
Who does your child currently live with?			
Names	Age	Relationship to child	Grade/Job

Who are your child's significant others NOT living with your child?			
Names	Age	Relationship to child	Grade/Job

Are child's parents? (please circle one) Married Separated Divorced Widowed Not Married

If parents divorced/separated please list dates:

Who in the family is your child closest to?

What are some of the strengths of your family?

Is there anything else that you think would be important for me to know about your child, you, or your family?